PRINTED: 04/12/2011

DEPARTMEN'	T OF HEALTH AND HUMAN SERVICES			FORM APPROVED	
CENTERS FO	R MEDICARE & MEDICAID SERVICES			OMB NO. 0938-0391	l
STATEME	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
	155679	B. WING		03/24/2011	
NAME OF	PROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY, STATE, ZIP CODE	•	
TO EMIL OF	TRO VIDER OR GOLLEIER		ELSDALE DR		
BETHLE	HEM WOODS NURSING AND REHABILITATION C	ENTE FOR	T WAYNE, IN46835		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE COMPLETION	1
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0000	This visit was for a Recertification and	F0000	The creation and submission	of	
10000	State Licensure Survey.	10000	this Plan of Correction does r	not	
	State Electionic Bulvey.		constitute an admission by th		
	Survey dates: March 21, 22, 23, & 24,		provider of any conclusion se	t	
			forth in the statement of deficiencies, or of any violation	on of	
	2011		regulation.The provider		
	F 111 1 0000 (0		respectfully requests that the		
	Facility number: 000260		2567 Plan of Correction be		
	Provider number: 155679		considered the Letter of Cred	I	
	AIM number: 100267820		Allegation.Based on past sur	· I	
			history and no harm identified any resident; this facility	1 10	
	Survey team:		respectfully requests a desk		
	Sue Brooke,r RD TC		review in lieu of a post survey	,	
	Rick Blain, RN		revisit on or before April 15, 2	2011.	
	Christine Fodrea, RN				
	Sheryl Roth, RN				
	Census bed type:				
	SNF/NF: 86				
	Total: 86				
	Census payor type:				
	Medicare: 8				
	Medicaid: 59				
	Other: 19				
	Total: 86				
	10.61. 00				
	Sample 18:				
	Supplemental sample: 1				
	Supplemental sample. 1	1		I	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

findings cited in accordance with 410 IAC

These deficiencies also reflect state

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

16.2

Event ID:

G53411

Facility ID:

000260

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155679		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED 03/24/2011			ETED		
133079			B. WIN			03/24/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE LSDALE DR		
		SING AND REHABILITATION CEN	NTE	FORT V	VAYNE, IN46835		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	Quality review co	ompleted on March 27,					
	2011 by Bev Fau	lkner, RN					

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
	155679		B. WING			03/24/2	011	
<u> </u>			D. WIIW		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF PROVIDER OR SUPPLIER					LSDALE DR			
BETHLEHEM WOODS NURSING AND REHABILITATION CEN		ITE		WAYNE, IN46835				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0514	Based on observa	ation, record review and	F05	14	F 0514 It is the practice of this		04/15/2011	
SS=D	interview, the fac	cility failed to ensure a			provider to ensure a thorough			
00-D		mprehensive clinical			comprehensive clinical record	,		
	_	g readily accessible			supplying readily accessible sufficient information for all			
		ation for 1 of 1 residents			residents.What corrective			
	in a supplementa				action(s) will be accomplished	for		
		-			those residents found to have			
	wound/scab. (Re	esident #5)			been affected by the alleged			
					deficient practice:The skin			
	Findings include	:			assessment, nurses notes and			
					wound skin evaluation report f			
	On 3/21/11 at 7:5	50 a.m., a red open area			Resident #5 is available in the clinical record. How will you			
	the size of a quar	rter was noted to the			identify other residents having	the		
	1	ehead of Resident #5.			potential to be affected by the			
		the perimeter of the area			same alleged deficient practice	е		
		r. Also noted were			and what corrective action will	be		
	1 ^				taken: All residents with skin			
	abrasions over th	ie ieit eyebrow.			alterations have the potential t	0		
					be affected by the alleged deficient practice. The clinical			
		inical record of Resident			records for residents with skin			
	#5 on 3/21/11 at	10:00 a.m. and on			alterations will be audited no le			
	3/23/11 at 2:00 p	o.m., indicated the			than weekly to ensure records			
	following: Resid	dent #5's diagnoses			complete and accurately			
	· ·	re not limited to, chronic			documented.The clinical recor	ds		
	1	onary disease and atrial			will be maintained and kept			
	fibrillation.	and and an			readily accessible and			
	iioiiiatioii.				systematically organized.Education will be			
	The Winder 11	Linear Teers Dress as			completed by April 15, 2011 fo	rall		
	1	linary Team Progress			licensed nurses and			
	· · · · · · · · · · · · · · · · · · ·	/1/11," under social			Medical Records personnel by	,		
	services, indicated Resident #5				the Director of Nursing.			
	"explained her	cont. (continued) back			Education will include accurate	ely		
	pain and her eye	burns - per DNS			documenting complete skin			
	(Director of Nurs	sing Services) will refer			assessments, nurses' notes a			
	to NP (Nurse Pra	· ·			wound skin evaluation reports review of the Skin Manageme			
	() ()	- 7			Program and maintaining read			
					1 1 2 3 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	,		

000260

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
15567Q		B. WIN			03/24/2011			
2712 == =:					ADDRESS, CITY, STATE, ZIP CODE	1		
NAME OF F	PROVIDER OR SUPPLIEF	₹		4430 E	ELSDALE DR			
BETHLE	HEM WOODS NUR	SING AND REHABILITATION C	ENTE	1	WAYNE, IN46835			
(X4) ID	SUMMARYS	STATEMENT OF DEFICIENCIES	1	ID	<u> </u>	(X5)		
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
		rd review on 3/21/11 at		1110	accessible and systematically			
	"				organized records.What	′		
		3/23/11 at 2:00 p.m., the			measures will be put into place	ce or		
	1 *	clinical record regarding			what systemic changes you v			
	the wound/scab/	abrasions to Resident #5's			make to ensure that the alleg	ed		
	forehead were th	ne following, none of			deficient practice does not			
	which explained	how the wound/scab was			recur:The clinical records for			
	acquired:				residents with skin alterations			
	acquired.				be audited no less than week			
	113.7				ensure records are complete	and		
		" dated 3/20/11 12:30			accurately documented. The clinical records will be mainta	inod		
	a.m., signed by I	LPN #1, did not contain			and kept readily accessible a			
	any information related to the resident's				systematically	iiu		
	forehead, scab, b	preathing treatment or			organized.Education will			
	problems with b	•			be completed by April 15,			
	proorems with or				2011 for all licensed nurses a	ind		
	"Numana Mataa	" data d 2/21/11 at 5:00			Medical Records personnel b	у		
	·	" dated 3/21/11 at 5:00			the Director of Nursing.			
	1	LPN #2, indicated			Education will include accura	tely		
	Resident #5 had	a scab to her forehead.			documenting complete skin			
					assessments, nurses' notes a			
	- "Nurses Notes,	" dated 3/22/11 at 2:15			wound skin evaluation reports			
	·	Resident #5 had an intact			review of the Skin Manageme Program and maintaining rea	•		
	l '	lead with no drainage or			accessible and systematically	•		
		lead with no dramage of			organized records. How the	′		
	discomfort.				corrective action(s) will be			
					monitored to ensure the alleg	led		
	- "Nurses Notes,	" dated 3/22/11 at 9:00			deficient practice will not recu			
	a.m., indicated a	scab continued to			CQI monitoring tool will be ut			
	Resident #5's for	rehead. The skin was			every week x 4, monthly x 3 a	•		
	slightly red but i	ntact and a new order was			quarterly thereafter.Data will			
	, ,	biotic ointment and			submitted to the CQI committ			
	Band-Aid daily				If threshold is not met, an act	IOH		
	Danu-Alu dany i	unin resorved.			plan will be developed.Non-compliance w	vith		
					facility policy/procedure may	VIGI		
	- The physician:	signed,"Interdisciplinary			result in disciplinary action ar	nd/or		
	Progress Note,"	dated 3/22/11, indicated			re-education.			
	on exam, Reside	ent #5 had scabbed						
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	L G53411	Facility	ID: 000260 If continuation	sheet Page 4 of 8		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155679			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		A. BUILDING B. WING 03/24/:				011	
NAME OF PROVIDER OR GURNIER			D. 1111		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF PROVIDER OR SUPPLIER				4430 EI	LSDALE DR		
BETHLEHEM WOODS NURSING AND REHABILITATION C			ENTE	FORT V	VAYNE, IN46835		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		nidbrow and left brow.		1110			DATE
	excoriations to in	ndorow und fort brow.					
	- "Nurses Notes,"	dated 3/22/11 at 10:00					
	· ·	Band-Aid was observed					
	1 *	esident #5's forehead.					
	- And the last ent	try on the page was noted					
	3/23/11 at 9:00 a	.m., followed by five					
	blank lines. The	note indicated the scab					
	continued to Res	ident #5' forehead and					
	the skin was slig	htly red around the area.					
	Not available on	the clinical record at the					
		view was the "Weekly					
		," dated 3/20/11 signed					
		no time listed, which was					
	*	Director of Nursing on					
	^	p.m The assessment					
	indicated Resider	•					
		h described as "slight					
		petween eyebrowsnoted					
	_	ng, skin intact, then					
	scabbed in the A	•					
	The "Peer Review	w Document," dated					
	3/20/11, with no	time listed, which is not					
	a part of the clini	cal record and is used for					
	internal facility q	quality improvement, was					
	provided by the I	Director of Nursing on					
	3/24/11 at 12:00	p.m. The documented					
	listed that during	a breathing treatment,					
	Resident #5 com	plained of the mask					
	poking her foreh	ead. The mask was					

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		155679	B. WIN	011			
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	LSDALE DR		
BETHLE	HEM WOODS NUR	SING AND REHABILITATION CE	NTE	FORT V	WAYNE, IN46835		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		sharp areas noted. The					
	-	ed the mask with a new					
		athing treatment was					
		te further indicated the					
		ed to scratch between her					
	eyebrows causing	g the area to be pink with					
	intact skin. "Res	ident in the morning to					
	have smooth bro	wn scab intact between					
	browsno draina	age or redness noted"					
	The note was sig	ned by the nurse on duty					
	during the shift (LPN #1).					
	,						
	Also not availabl	le on the clinical record,					
		narting book during the					
		view, was a sheet of					
		ed 3/11/11 thru 3/21/11,					
	·	ided by the Director of					
	•	on 3/24/11 at 10:30 a.m.					
	• • •	ted at that time, she had					
		he documents and wasn't					
	_						
	-	looking for them so they					
		nical record. The notes					
	included the follo	owing:					
	The "Nimmer Ni	otes " detect 2/20/11 et					
		otes," dated 3/20/11 at					
	•	ted an area on the					
		k and appeared to be					
	scabbed for Resid	dent #5.					
	!!NI NI	U Jaka J 2/21/11 - 4 0.00					
	- "Nurses Notes," dated 3/21/11 at 9:00						
	a.m., indicated so	cab continues to forehead.					
	A "Wound Skin I	Evaluation Report," dated					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LDING		COMPLETED	
	155679		B. WIN			03/24/2	.011
			p. ,, 11		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R		1	LSDALE DR		
BETHLEHEM WOODS NURSING AND REHABILITATION CE			ENTE	1	VAYNE, IN46835		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	<u> </u>	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	1	by the Assistant Director					
	of Nursing/Wou	and Nurse did not list a					
	time of the asses	ssment. This note was					
	also not availab	le during the time of					
	record review b	ut was provided by the					
		or of Nursing/Wound					
		1 at 11:45 a.m. The note					
	indicated Reside						
	1	easuring 3.4 a.m. by 2.6					
		th of less than 0.1 c.m.					
	_						
	with a dark brown intact scab.						
	On 3/24/11 at 16	0:20 a.m., Resident #5					
		otained the scab to her					
	1						
		staff gave her a breathing					
		tly and the mask was too					
	1 -	oking her. She further					
		was changed to a new one					
	-	pplied the new mask, it					
	again was too ti	ght.					
		1:25 a.m., the Director of					
	Nursing indicate	ed there was no need for					
	further documen	ntation since there was					
	nothing on the s	kin at the time of the					
	incident to show	there was anything open					
	1	d when the resident went					
	1	ing (3/19/11)there was					
	nothing on her forehead and the skin was intact but when the first shift came on						
	1	eab was noted. She stated					
	1 ' / '	nsidered intact so there					
	1	further documentation of					
	was no need for	Turnici documentation or					

000260

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		IDENTIFICATION NUMBER			NSTRUCTION	(X3) DATE SURVEY COMPLETED 03/24/2011	
155679			A. BU B. WI	ILDING NG			
NAME OF PROVIDER OR SUPPLIER BETHLEHEM WOODS NURSING AND REHABILITATION C				STREET A	DDRESS, CITY, STATE, ZIP CODE SDALE DR VAYNE, IN46835		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E RIATE	(X5) COMPLETION DATE
	provided by the 1 3/24/10 at 10:40 indicated "Any direct care givers shower days mus licensed nurse fo include bruises, of tears, blisters, an nurse is responsi- all skin alteration	ogram,", dated 3/10, was Director of Nursing on					